

Health Care Reform in the United States: An Opportunity for Interventional Radiologists

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ABBREVIATIONS

ACO = accountable care organization, CMS = Centers for Medicare and Medicaid Services, PPACA = Patient Protection and Affordable Care Act, RVU = relative value unit, SGR = sustainable growth rate, VBM = value-based modifier.

Health care reform is an ongoing reality in the United States. This communication provides a concise description of the context in which this reform has emerged, explains the major provisions being translated through providers as of today, and elucidates potential opportunities in this dynamic environment for interventional radiologists.

According to Medicare trustees, the Medicare fund will be bankrupt by 2026 because of soaring health care expenditures (1,2). Expenditures, or “costs,” as referred to in this setting, represent dollars charged for medical care, procedures, and hospital stays, as well as the dollars paid to insurance companies on behalf of patients. Cumulatively, these costs represent 18% of the gross national product, or \$2.7 trillion (3). Despite this exorbitant spending, the United States ranks poorly in several important health care outcome metrics, including male and female life expectancies, infant mortality, and obesity, among others (4–6).

In 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA), a law comprising almost 2,500 pages that outlines provisions to be implemented over 10 years that aim to (a) improve access to health care, (b) improve the quality of patient care, and (c) realign the focus of providers with fiscally responsible behavior. Although these aims are interdependent to a great degree, two major themes emerge from analysis of the law. First, the law expands medical insurance coverage of individuals through health insurance market reform, elimination of preexisting condition restrictions, individual and employer mandates, health

insurance exchanges, federal subsidies for the poor, and expanded access to Medicaid. The funding for these changes will result from taxes on health care industry companies, penalties on those who remain uninsured or fail to provide insurance, and provider cuts (7,8).

Second, provisions are included over time to improve quality of patient care and to control costs. This latter theme seeks to integrate improved efficiency and cost savings at the provider level in an effort ultimately to decrease spending and to improve further access to care (7,9–11). If one considers the payer → provider → patient chain structure of health care (Fig 1), the idea of decreased costs at the provider level is sound. It would increase retained earnings of the payers, maintaining Medicare as a source of income for providers and allowing private insurers to charge less to patients, which would ultimately improve access from the patient side through lower costs. Mission accomplished? Almost—except for the lurking relative value unit (RVU) saboteur.

SUSTAINABLE GROWTH RATE AND RVUS

RVUs were developed as a method of accounting for physicians’ work effort and adopted by Medicare and private insurers as a reliable and reproducible method for setting fee-for-service schedules (12,13). At the present time, the Relative Value Scale Update Committee is a group of specialists who evaluate and determine the appropriateness of RVUs, and their recommendations are adopted by the Centers for Medicare and Medicaid Services (CMS) (14). RVUs are calculated by assigning a numerical value to a service, as determined by the Relative Value Scale Update Committee through consideration of three factors: (i) relative time, skill, training, and intensity required (work RVU); (ii) costs associated with maintaining an overall practice to render such services (practice expense RVU); and (iii) costs associated with liability insurance required to perform the service (malpractice RVU). This value is multiplied by defined (by the CMS) geographic practice cost indices

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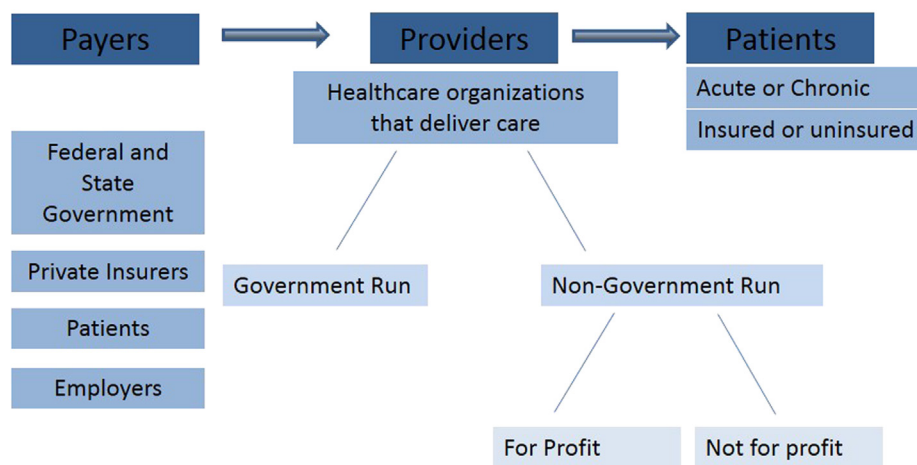
to account for geographic differences in the cost of practice throughout the United States and finally converted to a dollar amount through a conversion factor determined in Congress, which for 2013 was 34.023 (Fig 2) (15,16).

The sustainable growth rate (SGR) is a formula used to calculate this conversion factor ultimately to adjust RVUs for the yearly Medicare Physician Fee Schedule. The goal of this formula is to control Medicare reimbursements as they relate to the gross domestic product. Specifically, as the number of services increases over time, the reimbursements are adjusted to control overall expenditures so that the rate of increase in costs per Medicare beneficiary (average payment paid on behalf of a Medicare beneficiary) does not exceed the gross domestic product per capita increase for a given year (17,18). Increasing procedures and costs have resulted in recommendations to decrease physician payments,

interrupt rate increases multiple times, or both. The prevailing fear is that enacting such decreases would create a barrier to care for Medicare beneficiaries. That is, rather than contend with increasing volumes and decreasing rates, physicians would elect not to treat Medicare patients. For this reason, proposed cuts have accumulated over the years because Congress has elected not to implement them; for 2013, the SGR called for 27%–29% decreases in physician reimbursements (17).

As a mechanism for determination of dollar value for service, the RVU has been resilient (1). However, the RVU also was employed in a separate arena to measure, cross-compare, and compensate for physician productivity (19–21). The last of these, compensation, generates a powerful force against cost reduction and represents a landmine for the PPACA because overall expenditures are continually driven up by physicians motivated through RVU-based compensation schedules (14,22,23). The

Structure of Healthcare Expenditures in the United States*



*Figure courtesy of Sayan Chatterjee, Ph.D. Professor of Policy and Management. The Case Western Reserve University Weatherhead School of Management.

Figure 1. Cost structure of U.S. health care. (Courtesy of Sayan Chatterjee, Ph.D., Professor of Policy and Management, The Case Western Reserve University Weatherhead School of Management.) (Available in color online at www.jvir.org.)

Non-Facility Payment Amount

$$[(\text{Work RVU} * \text{Work GPCI}) + (\text{Non Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})]$$

* [Conversion Factor adjusted for budget neutrality]

Facility Payment Amount

$$[(\text{Work RVU} * \text{Work GPCI}) + (\text{Facility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})]$$

* [Conversion Factor adjusted for budget neutrality]

Figure 2. RVU calculations. The facility/non-facility designation identifies where services are provided. The facility pricing amount generally covers services to inpatients or in a hospital outpatient clinic setting but can include other settings. Off-site hospital-owned sites are also considered as “facilities” in the context of payment. Non-facility services are generally provided in a freestanding physician’s office but can include other freestanding settings. GPCI = geographic practice cost index, MP = malpractice, PE = practice expense, RVU = relative value unit.

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